between graduate numbers and posts available than is already envisaged. Such specialization may be no bad thing but it does also have implications for surgeons in their public servant role. It may well be that in the future consultants need to be appointed to a rolling contract renewable after a variable length of time. This will enable manipulation of numbers of specialists' posts in a particular region to comply with demographic and other changes. Should a particular specialty become over-subscribed, it will be possible for employing authorities to require consultants, as contracts come up for review, to either move with suitable financial assistance or to re-accredit in another specialty understaffed at that time. Such a form of renewable contract would be applicable until the age of about fifty when such upheaval would result in an appreciable loss of productivity. Many others in the professions, commerce and industry are required to move location. Such a possibility does reflect how the doctors' perceived career may have to alter in the light of changing public opinion within a resource-limited Health Service. Suitable facilities will also need to be available for re-accreditation training.

The recent increase in insurance premiums, consumer pressure and the current welcome emphasis on audit means that some form of quality control may soon be forced upon surgeons, either by employing authorities or by indemnifying agencies. A system of re-certification of practising doctors may be demanded every few years as it is in some states in America. Failure to satisfy the imposed requirements would result in temporary suspension of practising rights. This means that an appropriate setting will have to be achieved for the re-certification training of these senior doctors. In any event education arrangements will need to be continued well beyond the stage required to date.

Surgical training must remain the amalgam of art and science that it has been since the days of Hippocrates. There must be a willingness to change in both attitude and performance with a speed compatible with the late 20th century. Many great institutions have declined to the status of dinosaur over very few years, resulting in their own extinction because of reluctance to face up to their own shortcomings. Surgery has to continue and therefore will be forced to adapt. It behoves the profession to orchestrate its own future rather than accept an inevitably subordinate role imposed from outside. The plea is for change, but let that change be both structured and constructive. Without a well trained, well motivated and compassionate surgical work force there is one certain loser - the patient.

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Undifferentiated illness: some suggestions for approaching the polysymptomatic patient

General practitioners are well aware of that sudden sinking feeling when a complicated polysymptomatic, over-investigated and undiagnosed patient enters the surgery. Often there is little that can be done for this individual and as a consequence we may feel medically impotent. The doctor's inability to deal with this situation may force him to focus his frustration and aggression on the patient and, as a consequence, blame the patient for their illness. The doctor is almost invariably in a dominant situation in the consultation. Consequently it is very simple to push the illness back at the patient without necessarily offering any constructive advice as to how the patient may cope better with their situation, and thereby reach a more healthy lifestyle.

It is possible, however, within conventional medicine, to adopt a more positive and receptive approach to the polysymptomatic patient. For the general practitioner this usually means attempting to assess the disease in the context of its social, psychological and clinical elements.

In medical school we spend a vast majority of our time learning about differentiated illness. These are illnesses which present with classical groups of signs and symptoms. Our provisional diagnosis on history and examination is usually confirmed by the demonstration of a typical pattern of functional haematological, biochemical and X-ray studies. Diseases such as asthma, rheumatoid arthritis and duodenal ulcers are typical of the group defined as differentiated

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illness. Many doctors consider this type of problem to be the 'real diseases' which they were trained to diagnose and manage.

Undifferentiated illness represents the bulk of a general practice case load[1]. By its very nature, undifferentiated illness is difficult to define, but as with differentiated disease it can be both acute and chronic. I should like to view undifferentiated illness as a problem that presents with clearly defined but often variable symptoms, but above all else does not fit into a defined diagnostic pattern recognizable to conventional medicine. For instance, the patient who presents with persistent abdominal distension, excessive sweating and palpitations may well initially receive some conventional investigations. However, if these are normal the patient will often be considered to have a psychosomatic illness and in many instances little more will be done for them. The conventional doctor will tend to look at the majority of undifferentiated illness as being psychological or psychosocial in origin. But can this really be correct, do we really understand enough about medicine to realistically be able to exclude somatic causes for all illness?

I would like to suggest a third approach. We should consider that some undifferentiated disease as organically based and as a consequence can be treated successfully with material therapies that have greater than a placebo effect. For instance, many polysymptomatic patients can be managed using an approach based on food and chemical sensitivity (clinical ecology)[2]. This third approach is largely dependent on the subtle application of the disease models that exist within the complementary therapies.

Many of those working within the complementary therapies see undifferentiated illness in a completely different light. The homoeopath considers that a vast range of symptoms may be important, many of which will undoubtedly be ignored by the conventional doctor. As a consequence, conventional diagnostic entities, or differentiated illness, are only one aspect of the homoeopath's case analysis. The same may be true of the acupuncturist.

Furthermore, both these disciplines in their classical form do not make the clear division between the presence or absence of visible or material pathology, that is made by conventional medicine. For instance, the acupuncturist will make a diagnosis of an abdominal complaint that within the view of traditional Chinese medicine would be an adequate basis upon which to proceed with either herbal or acupuncture-based treatment. The traditional Chinese diagnosis will not distinguish between the presence or absence of an actual ulcer. In this way the traditional Chinese physician may be diagnosing and treating prepathology as he sees illness as a continuum initiated by an energetic imbalance, that may give rise to an ulcer. The subtle initiating factor being more important than the ulcer itself. It is interesting to note that many polysymptomatic patients eventually display severe organic illness[3]. The hypotheses within complementary medicine are powerful in that they give us an approach to prepathology, which if effective, might avoid the subsequent development of serious and irreversible illness.

If a small child presents with croup at 3 months, followed by repeated ear infections between the ages of 3 and 5 years and then by asthma at a later stage in his life, the conventional doctor may not connect these illnesses. He will probably consider the patient to be a chronic catarrhal child and as a consequence would not look for a cause which may allow him to approach the child's general and possibly continuing ill health. The picture described is common in general practice, and it would seem logical, therefore, to look for an aetiological factor. The clinical ecologist or food allergist would immediately consider that the patient presenting with this pattern of illness may have a food intolerance. He would attempt to define a therapeutic approach based on food avoidance in order to help the child, and may therefore avoid subsequent episodes of illness such as severe headaches or worsening asthma. This different approach implies that even episodes of defined disease may be part of a pattern of illness which conventional medicine does not analyse adequately. Therefore, using some of the diagnostic approaches within complementary medicine, may give the doctor a powerful tool with which to unravel the patient's problems[4].

The same thought process can be applied to undifferentiated illness. Complaints of general malaise, headache and urgency, with no obvious organic cause, may well be psychological. However, they could also represent a mineral or vitamin deficiency or indeed a food allergy.

At first glance it may seem that there is little in common between such disparate disciplines as acupuncture, homeopathy and osteopathy. However, all these approaches are in origin vitalistic. They all assume an intuitive belief in some form of life force. The therapies and disease models that are applied within the field of complementary medicine are designed to specify subtle imbalances within the body and 'rebalance' the individual, thereby returning them to a state of health. Conventional scientific medicine is the only medical system developed so far that has failed to include a vitalistic approach within its philosphy. It assumes, presumably intuitively, that illness can be explained using a reductionist model. Both these diametrically opposed hypotheses represent acts of faith. They are beliefs rather than absolute truths. It surely behoves us to explore every option in order to help our patients.

Many conventional doctors view the complementary therapies as 'add-on therapies'. Interest in acupuncture has expanded over the last few years, particularly since the discovery of encephalins and endorphins. Many anaesthetists have, therefore, taken acupuncture into the realm of conventional medicine and it is now practised in the majority of pain clinics in the United Kingdom. However, much of the foundation of traditional Chinese medicine has been ignored by these doctors. As a consequence they are poor and clinically unadaptable acupuncturists as the disease models within traditional Chinese medicine are unknown to them. They view acupuncture as an 'add-on therapy' that can be easily mastered by the conventional doctor. Conventional doctors focus on the act of needling rather than the thought processes and disease models that form the foundation of acupuncture. In conventional terms this is rather like a surgeon who is obsessed with and only understands detailed surgical techniques, but knows nothing about pharmacology, pathology or general medicine. The theoretical concepts within traditional Chinese medicine are rich and may provide us not only with greater insight into acupuncture, but also with a better understanding of undifferentiated illness.

The stated view of the British Medical Association and by implication some conventional physicians is that they are reluctant to accept these approaches without understanding their basic mechanism. This seems somewhat hypocritical as we understand so little about so many of the mechanisms and treatment of illness within general practice. Further study of the claims of acupuncturists and homeopaths may actually lead us into a better understanding of undifferentiated illness. Their approaches, based on balancing the body, should not be dismissed lightly. The complementary therapies may also offer us a valuable insight into the links that exist between various differentiated or defined diseases. An exploratory leap into the conceptual realms of complementary medicine may represent an excellent window through which to understand better some of the currently insurmountable problems within general practice. As a by-product, these therapies may also provide cheap, safe approaches to illness.

Acknowledgments: I would like to acknowledge the help and constructive suggestions of my colleague, Dr Bruce Thomas.

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